



NAVY DEPARTMENT

# BUMED NEWS LETTER

a digest of timely information

Editor - Captain Cecil H. Coggins (MC), USN

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(Not Restricted)

Refrigeration in the Treatment of Shock: The use of refrigeration in the treatment of traumatic shock is based upon the rationale of localized, metabolic depression. From this viewpoint, whatever theory of the genesis of traumatic shock may be held to lie closest to the truth, a reduction in metabolism at the site of injury should prove efficacious.

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Proponents of the neurogenic hypothesis attribute the reported benefits derived from the application of cold to a reduction in the frequency of afferent impulses arising from the damaged area. Those who believe in "shock factors" and "depressor substances" as causative agents in traumatic shock may explain the effects of cooling in terms of a depressed metabolism of the injured area with reduction in the formation of toxic factors. By the same reasoning, one may hold that abnormal fluid and electrolyte (K, Na) shifts across cellular membranes are held in abeyance by the application of cold. It is true, however, that generalized fluid loss as conceived in the classic theory of the "white hemorrhage" is not in keeping with these lines of reasoning, and the concept of generalized capillary leakage in shock has recently been almost universally discarded in favor of the view that the alterations in capillary permeability characteristic of shock are confined to the site of insult. This line of thought is consistent with recent claims concerning the role of organisms of the Clostridium group in shock. According to these claims, the organisms normally present in muscle multiply rapidly in traumatized (anoxic) tissue and invade the blood stream. Cooling of the tissue would tend to reduce the metabolism of the organism as well as that of the surrounding tissues.

The application of refrigeration technics theoretically accomplishes these purposes: (a) hemostasis, (b) anesthetic action, (c) reduction of shock, (d) lowering of tissue and bacterial metabolism. As a result of the latter effect, refrigeration has been found to be of benefit in the prevention of necrosis in surgery during the establishment of collateral circulation, and in cases of gas gangrene. The use of refrigeration is limited, however, by the availability of refrigerants and by the mechanical limitations of application to the body. (Res. Div., BuMed - E. L. Corey)

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Ineffectiveness of Penicillin in Tetanus: A clinical study of 16 cases of established generalized tetanus failed to show evidence of any beneficial effect of penicillin upon the course of this disease. There was no obvious fall in the temperature or in pulse rates as has been repeatedly seen in infections susceptible to penicillin. There was no decrease in mortality or morbidity, or any definite decrease in the severity, duration and frequency of the convulsive seizures.

The evidence indicates that, until some direct attack is possible upon the fixed toxin or the products of its fixation in the central nervous system, the successful management of tetanus depends not upon chemotherapy but upon early diagnosis, adequate serotherapy for neutralization of free toxin, control of the convulsions, and general supportive measures. (OEMcmr, Altmeier, Univ. of Cincinnati, Ms. for publication - CMR Bulletin #61)

Mechanism of Persistent Headache Following Head Injury: With the exception of those headaches associated with posttraumatic subdural hematoma, and occasionally with subarachnoid hemorrhages, chronic headache following trauma to the head results mainly from noxious stimuli originating on the outside of the skull.

Such headaches result from sustained contraction of skeletal muscle of the scalp and neck associated with the occurrence of sustained resentment, anxiety, frustration, tension and fear. They are sometimes augmented by noxious stimuli arising from abnormal healing processes within the extra-cranial soft structures of the head and neck. Muscle contraction, although minimal in amount, is probably the basis of complaint in many instances because it is sustained and because the patient has an abnormal preoccupation with the head. Since all patients in this study gave evidence of emotional disturbance, it is likely that they overreact to minimal head sensations which would be disregarded by other persons.

In a small proportion of patients with posttraumatic headache, distended cranial vessels are the source of noxious stimuli which give rise to the headache. Such headaches resemble migraine headaches in quality, mechanism and response to ergotamine tartrate.

Vertigo, listing, pallor, sweating, nausea and pulse changes which accompanied the posttraumatic headaches, and induced by sudden change in position or movement of the head, were experimentally reproduced and studied. It is inferred that they were the effects of spread of excitation within the brain stem, resulting from noxious stimuli arising in the skeletal muscles and in their attachments at the base of the skull. Scotomata, associated with posttraumatic headache, were also experimentally reproduced and studied, and are considered to be due to spread of excitation within the cerebral cortex secondary to noxious stimuli arising in skeletal muscles about the head.

Chronic headaches which follow trauma to the head closely resemble, as regards the basic patho-physiological mechanisms and symptomatology, other headaches which accompany and follow stress and untoward life-situations, but which are unrelated to head trauma. (OEMcmr-485, Simons and Wolff, Cornell Univ. - CMR Bulletin #60)

Grafting of Infected Bone Defects: Bone grafting has been accomplished both experimentally and clinically under penicillin therapy at the time of the surgical treatment of open infected bone defects. A course of several days of penicillin therapy should precede each surgical procedure. The duration of

postoperative penicillin therapy should vary somewhat with the size and type of the bone grafts, the vascularity of the area, the bacterial flora of the wound, and the condition of the soft tissues underlying the bone defect. In cases with very small infected bone defects filled with cancellous bone grafts and covered with well-vascularized and rapidly-healing soft tissues, and with cultures showing penicillin-susceptible organisms, a minimum of 3 weeks' postoperative penicillin therapy may be sufficient. In patients with large grafted defects, or with grafts containing considerable cortical bone, or with areas that are slow to revascularize, postoperative penicillin therapy should be continued for from 6 to 8 weeks, and occasionally longer. Since penicillin has become readily available, daily doses of at least 200,000 units have been used. (OEMcmr-431, Naffziger, Univ. of Calif. - CMR Bulletin #60)

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Hypercalcinuria Following Fracture and Osteotomy: After fracture or osteotomy the urinary calcium excretion of immobilized patients is at first normal. It then rises steadily to a plateau which is maintained for a prolonged period. The maximum excretion of calcium in 17 patients ranged from 295 to 670 mg./day, with an average of more than 500 mg./day. The sustained excretion level was altered very little by dietary changes or by administration of calciferol or alkalies.

Since patients with fracture or osteotomy excrete more calcium than do healthy immobilized men, it seems probable that the inflammatory reaction about the site of the injury plays some part in augmenting the calcium loss. The possibility is considered that this effect is due to vascular reflexes resulting from the injury and from the subsequent processes of repair. (OEMcmr-189, Howard et al, Johns Hopkins Univ., Ms. for publication - CMR Bulletin #54)

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Pneumonitis Occurring in Rheumatic Fever: Pneumonitis is a manifestation of rheumatic fever characterized by an inflammatory process of the lung and pleura with an insidious onset, migrating consolidation, and frequent pleurisy with or without effusion.

In a group of 1046 rheumatic fever patients observed in the rheumatic fever unit at the U. S. Naval Hospital, Corona, California, the incidence of pneumonitis was 11.3 per cent. Table I shows that the most frequent occurrence was in the acute and polycyclic types of the disease. No demonstrable pneumonitis was found in the subclinical types.

TABLE I  
Incidence of Pneumonitis

Type of Rheumatic Fever	Number of Patients	Number who developed Pneumonitis	Percentage with Pneumonitis
Acute			
Fulminating	52	28	53.1%
Polycyclic	281	77	27.4%
Monocyclic			
subacute	667	14	2.0%
Subclinical	46	None	0.0%

The gross and microscopic pathology is discussed in detail in recent papers by Huntington and Griffith. In brief, gross examination reveals areas of mottling which are characteristic of infarction. The cut surface is smooth and, although hyperemic in appearance, is relatively bloodless. The mottled areas may be found in all lobes of the lungs. The histologic picture is that of an anaphylactic angiitis involving the larger vessels as well as the capillaries. There are endothelial proliferation, hemorrhage, necrosis and hyalinization. Perivascular infiltration of plasmocytes, giant cells, lymphocytes, myocytes with owl-eyed nuclei and relatively few polymorphonuclear cells is characteristic. The Aschoff bodies may be found freely in various stages of development and maturity. The alveoli are filled with collagen, fibrin and blood-cells. The pleura may show a fibrinous exudate on both the parietal and visceral membranes. Organization and formation of fibrous adhesions may occur, but more frequently there is little residual evidence of the pleuritis. An effusion occurred in 10.9 per cent of the cases. Effusions tend to be temporary. The fluid is sterile and straw-colored to sanguinous in appearance, depending upon the number of red cells. At times, large numbers of eosinophiles are found in the differential white cell count. The effusion may absorb very rapidly with very little residual evidence of the pleurisy.

There are three clinical types of pneumonitis recognizable, namely, (1) primary acute pneumonitis, (2) secondary acute pneumonitis, and (3) sub-clinical pneumonitis.

(1) Primary acute pneumonitis may be the presenting manifestation of rheumatic fever. The history of an upper respiratory infection several weeks previously, a period of latency, the development of shortness of breath on exertion, cough, occasional spitting of blood, fever of moderate to high degree,

tachycardia of greater degree than that usually found with the height of the temperature, cyanosis and restlessness are the symptoms and signs by which this manifestation may be suspected. On physical examination an area of dulness may be found in one or more lobes, accompanied by a suppression of the breath-sounds and a few fine, crackling rales. This area may develop into frank consolidation with increased dulness and tubular breathing. More frequently, however, the original area clears in two or three days and a new area develops. After two or three days other manifestations of rheumatic fever appear, such as migrating polyarthritis, carditis and a sustained relatively high fever. The diagnosis is confirmed by finding an area of cloudiness in one or more lobes of the lungs at X-ray study. There is a leucocytosis of moderate degree, without a marked shift to the left in the Schilling index. Study of the sputum usually reveals no pathogenic organisms and relatively few leucocytes. The sedimentation rate is usually high, and at times there is electrocardiographic evidence of myocardial change. The course of the primary acute type of pneumonitis is severe and prolonged. The pneumonitis may become so widespread as to cause a very greatly decreased oxygen-carbon dioxide exchange, with marked cyanosis and air hunger. At the same time, the pulmonary arterial tension rises to such a level that there may be primary right-sided heart failure. The heart which is the seat of a severe carditis is unable to meet the increased work load thrown on the right ventricle, and primary right ventricular failure may ensue. It is the opinion of the clinicians working in this group, that when there is primary right-sided heart failure in rheumatic fever, pneumonitis is one of the initiating causes. The pneumonitis subsides only as the other manifestations of the rheumatic fever subside, and the physical signs disappear long before the X-ray findings become negative.

In this series, the initial symptoms were referable to the lungs in approximately one-half of the cases of pneumonitis which developed in the patients with acute fulminating rheumatic fever. Most of the patients were treated for a primary atypical pneumonia until other manifestations of rheumatic fever appeared, such as polyarthritis and carditis.

(2) Secondary acute pneumonitis occurs during the course of established rheumatic fever. In Table I it is noted that secondary acute pneumonitis occurs most frequently in the polycyclic type of rheumatic fever. The onset may begin late in the first cycle, but more frequently it is one of the presenting manifestations of the second or third cycle of the polycyclic type.

The symptoms are those of shortness of breath, cough, pain and restlessness. Cough may be primary and severe, or mild to absent. Pain is usually late in its appearance as a symptom, but is severe and prolonged unless an effusion develops. Cyanosis is present only if involvement of the lungs is widespread. Restlessness is an early and persistent symptom.

The first signs to appear are fever and tachycardia. Dulness over localized areas of the lungs appears early and may shift from one lobe to another or within one lobe. The dulness may increase to flatness with the development of massive involvement of a lobe or with a rapidly-developing effusion. Early in the course, the breath sounds are diminished over the area of dulness. As the area of involvement increases, tubular breathing may develop, but this is relatively infrequent. Rales at first are small and finely crackling. Later the rales increase in number and become more moist in nature. The signs may clear fairly rapidly, or they may persist as long as other manifestations are present. The X-ray study confirms the diagnosis by revealing an area of cloudiness at the site of the physical findings. Fever, tachycardia, leucocytes and blood sedimentation rate are elevated, usually in proportion to the severity of the rheumatic process.

(3) Subclinical pneumonitis is found accidentally. There are no symptoms and few, if any, physical signs. Subclinical pneumonitis may be suspected when a rheumatic fever patient is more ill than the clinical findings would indicate. The diagnosis is based entirely on the X-ray finding of an area of cloudiness either in the hilar area or in isolated fields of the lungs.

The characteristic findings in the X-ray studies in rheumatic pneumonitis and pleuritis are the rapid onset and clearance of densities in one area which suddenly appear in another area in the lung fields, the equal rapidity with which a pleural effusion may appear and as quickly disappear, and the close association of the pneumonic densities to the bronchovascular markings spreading into the adjacent parenchyma. At the onset, the area of cloudiness is similar to that seen in primary atypical pneumonia and that seen in sulfonamide sensitivity. There is localized patchy density without much shift of the mediastinum. At times the area of cloudiness may be triangular and near the periphery, resembling an infarction, and again it may be circular and central. Multiple and upper lobe involvement occurred more frequently in the very ill patients.

Pleurisy was not found as frequently as the early writers indicated. Most of the cases of pleurisy were confirmed by X-ray findings. Effusion accompanying pleuritis is not infrequent, occurring in 18.8 per cent of cases of demonstrable pleurisy. The incidence of pleuritis would be much higher if pain were taken as the diagnostic criterion. The criteria used in the diagnosis of pleurisy were pain, pleural friction-rub, positive X-ray findings of thickened pleura, peripheral pneumonitis and/or effusion.

The differential diagnosis is not easy. The diagnosis of pneumonitis of rheumatic origin is based entirely on the exclusion of other types of pneumonia, and the concomitant development of other manifestations of acute rheumatic fever. The concomitant manifestations which are most helpful in establishing

the diagnosis of rheumatic pneumonitis are carditis, migrating polyarthritis, purpura, erythema marginatum, epistaxis and subcutaneous nodules. The primary acute pneumonitis cannot be distinguished from primary atypical pneumonia either clinically, by sputum studies, by X-ray, or by blood studies.

- Bacterial pneumonia is differentiated by the sudden onset with chill, high fever, characteristic sputum, X-ray findings of lobar involvement, and the laboratory determination of the causal organism.

Tuberculous pneumonia is differentiated by a history of exposure, by the course of the pneumonia and the absence of the protean manifestation of an active rheumatic state.

Pleurisy with effusion cannot be differentiated from tuberculosis except by guinea pig inoculation. The development of carditis, migrating polyarthritis, erythema marginatum, and subcutaneous nodules aids in the differential diagnosis pointing to rheumatic fever rather than to tuberculosis.

The differentiation of rheumatic pneumonitis from congestive heart failure is based upon the following facts. In congestive heart failure air hunger and increased venous pressure are more marked, and there is an enlarged liver which is tender and which pulsates. Ascites and dependent edema soon develop. A tricuspid systolic murmur is frequently heard. Since pneumonitis frequently precedes congestive failure, careful observation and timing of events are necessary to recognize the state where the pneumonitis is complicated by congestive failure.

The laboratory aids are of little help in differential diagnosis except in lobar pneumonia. The blood sedimentation rate is elevated approximately to the same level in primary atypical pneumonia, in tuberculosis pneumonia and in rheumatic pneumonitis. The leucocyte count is elevated to from 20,000 to 25,000 cells, with a moderate increase in the granulocytes in all types of lung involvement except primary atypical pneumonia. The antistreptolysin titer is definitely elevated in rheumatic fever, with or without a pneumonitis, and serves to differentiate rheumatic pneumonitis from primary atypical pneumonia, bacterial pneumonia and from tuberculosis. (U. S. Nav. Hosp., Corona - Griffith et al)

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(Not Restricted)

Cobra Venom in the Treatment of Angina Pectoris: The administration of cobra venom to patients with angina pectoris resulted in an increase in the standardized exercise tolerance and in clinical improvement in 7 of the 12

(Not Restricted)

patients studied. Four of 5 patients who had been unresponsive to the usual medication employed in the treatment of angina pectoris responded favorably to therapy with cobra venom.

The optimum method of administration was 10 mouse units (1 c.c.) three times the first day, followed by one injection daily for seven days; bi-weekly injections of 1 c.c. were then necessary to maintain the effect. If therapy was interrupted, repetition of the initial course of therapy sometimes produced beneficial effects.

No untoward symptoms occurred with the dose recommended. Local pain invariably occurred, but in no case was it severe enough to warrant discontinuance of treatment.

Cobra venom does not prevent the electrocardiographic changes associated with exertion in patients with angina pectoris. Its action is therefore not that of coronary vasodilatation. (N. Eng. J. Med., Oct. 18, '45 - Freedberg and Riseman)

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(Not Restricted)

Aminophylline Antagonism of Experimental Coronary Constriction: Experimentally, the administration of aminophylline intravenously relieves the circulatory depression caused by the intravenous injection of postpituitary solution. The effect of aminophylline is a result of the inhibition of relaxation of the constricted coronary vessels responsible for the impaired cardiac function.

When the initial blood pressure is normal or high, aminophylline generally reduces any pressor action of the postpituitary to a lower, or to the original, level of blood pressure. This occurs simultaneously with restoration of cardiac functional efficiency.

When the initial blood pressure is low, at shock level, and the heart markedly weakened, aminophylline generally reverses the low blood pressure to a higher and steadier level coincidentally with, or shortly after, improvement of cardiac function. The blood circulation is generally improved. The benefits may be temporary in severe depression.

These results, together with those of other observers, indicate that the striking antagonism of aminophylline for the circulatory depression of postpituitary is fundamentally vascular. It is believed that these results provide an

(Not Restricted)  
experimental basis for the possible benefits that may be derived from aminophylline in functional coronary disease, such as constriction or spasm. The aminophylline is effective in doses of therapeutic order. (Stanford M. Bull., Aug. '45 - Hanzlik and Moy)

(Not Restricted)  
Prickly Heat and Impetigo: A meeting of dermatologists was recently held at the headquarters of U. S. Naval Medical Research Unit Number Two in Guam.

At this meeting, it was agreed that the clinically-related problems of prickly heat and impetigo are the most important ones in tropical dermatology, since from 70 to 80 per cent of all individuals in the Guam area are involved.

Prickly Heat: It was observed that high humidity, high temperatures, and increased physical activity were predisposing factors to prickly heat; and that it is aggravated by ingestion of hot drinks and the wearing of clothing which causes friction or prevents evaporation. The underlying cause appears to be the occlusion of orifices of the sweat glands.

Undoubtedly perspiration plays the leading role. Cooling the skin to accelerate evaporation of sweat seems to give relief and to cause objective improvement. Tanning, either by sunlight or ultraviolet lamps, was regarded as beneficial in some cases.

There was no general agreement as to the best medication. However, the following lotion can be recommended:

Rx:	Bismuth subnitrate	10.0
	Zinc oxide	10.0
	Menthol	2.0
	Camphor	2.0
	Aqua calais	
	Alcohol aa q.s. ad	240.0

Tropical Impetigo is a common cause of disability, distinguished from the impetigo of temperate zones by its geographical distribution and by certain other characteristics:

1. The condition appears in the axillae, periaxillary region, the groin and trunk rather than at the classical sites, the face and hands.

(Not Restricted)

2. It begins as a clear bleb erupting from normal skin. In a few hours the contents become cloudy.
3. The pustules rupture and leave saucer-shaped, centrally-depressed, adherent brownish crusts which persist for days or weeks.
4. The eruptions tend to be chronic and recurrent with slight to moderate pain and itching. Heat and perspiration aggravate all cases, even those under treatment.
5. On Guam, the principal microorganism recovered from the base of previously unopened lesions was Staphylococcus aureus hemolyticus.

All agreed that therapy of existing lesions was not difficult but that prevention of recurrences and appearance of new lesions was very difficult. The patients should be seen and treated several times daily. In general, salves were not regarded as beneficial.

Among the methods of treatment advocated were: opening lesions and painting with 2 per cent tincture of merthiolate followed by calomel powder; opening lesions and painting with 10 per cent silver nitrate, followed by a resorcin sulfur shake lotion; opening lesions and powdering with dried plasma powder containing 400,000 units of penicillin per pint; the administration of penicillin systemically, 10,000 units every three hours for several days after all lesions have dried up.

(Not Restricted)

The Effects of Centrifugal Force on Man: Herewith is presented the first of a series of three articles on the effects of centrifugal force on man. Studies on this subject are prompted by problems arising from effects of forces on humans induced by rapid changes in velocity or direction in aircraft.

The unit of measure of the natural force of gravity acting upon a body at rest is arbitrarily expressed as 1G. In a moving plane, changes in velocity or in direction of movement induce forces greater than the force applied to a body at rest, and these may be expressed in terms of multiples of G.

By convention, centrifugal forces acting upon the longitudinal axis of the body in the direction of head to feet are designated as positive (+) G. When the blood is thus driven toward the feet, sensations of heaviness and pressure are felt in the lower part of the body. Forces acting in the opposite direction are spoken of as negative (-) G, and in this case the forcing of the blood into the upper parts of the body causes congestion in the brain. Forces exerted by change in direction of movement and rotation of the body about one of its axes

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are principally +G, although in outside turns, the body is occasionally subjected to centrifugal forces acting towards the head, or -G.

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Investigations on centrifugal force have been undertaken in four general ways: (1) by experienced subjects in experimental aircraft, (2) by physiologists piloting various aircraft, e.g., Diringshofen, Davidson, (3) by mass study of pilots and their reactions, (4) by the use of man-carrying centrifuges.

The major effects of centrifugal force on man result from the increased weight of his body components, especially the blood. Carotid blood pressure and cardiac output are lowered, with impairment of circulation and of central nervous functions. Of these, vision suffers first owing to the retinal circulation being opposed by the intraocular pressure which, if artificially raised, lowers the G threshold for blindness. Total failure of vision may be preceded by a progressive rise of threshold, and light sense may outlast visual acuity. In a large group of pilots, large unaccountable differences in threshold occur. The average difference between greying and total failure of vision is 0.7 G. Central circulatory failure results in brief unconsciousness (not necessarily preceded by black-out if G is excessive and suddenly applied) followed, on recovery, by marked confusion or disorientation.

Raised blood sugar, benzedrine or adrenal cortical hormone scarcely influence visual impairment, and since susceptibility to the cerebral effects of G is increased during flight by oxygen lack (if severe, or aggravated by CO) the effects described are attributed to retinal and cerebral anoxia. Occlusion of the leg circulation raises, and reactive hyperemia lowers the black-out threshold to G. During the partial visual impairment as a result of a prolonged maneuver, muscular effort (abdominal straining) may raise the blood pressure and restore normality. A pilot's resistance to the stress may depend upon his general circulatory reactivity.

Prolongation of greatly altered G is a factor in creating physiological disturbances. Twenty G for 0.01 second, or 12 G for 0.1 second causes no visual or neurological disturbance. (Tolerance of brief large forces probably depends on the structural strength of the body.) Several minutes of acceleration insufficient to impair vision cause only fatigue. In flight, the acceleration which affects vision usually reaches its maximum before reflex compensation (autonomic or somatic) can occur.

Increased weight, as a result of +G, may immobilize the trunk, but the limbs, if supported, are movable at right angles to the acceleration. Rapid rotation of the head (or a turret) at about 20°/second under high G may cause

(Not Restricted)

temporary disorientation. Otherwise vestibular disturbances are uncommon in experienced pilots. (J. Physiol., June '45 - Stewart)

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Penicillin Treatment of Acute Syphilitic Meningitis: Ten patients with acute syphilitic meningitis were treated with penicillin injected intramuscularly. Nine of these ten patients have been followed for more than one year after treatment. All of them remain clinically well so far as any neurologic evidence of syphilis is concerned, six have attained seronegativity of the blood and all ten had completely normal spinal fluids at the latest examination. These results of treatment appear to be superior to those obtainable by chemotherapy with heavy metals. The intrathecal administration of penicillin in acute syphilitic meningitis is not necessary. (OEMcmr-393, Nelson and Moore, Johns Hopkins Univ., Ms. for publication - CMR Bulletin #60)

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Studies on Japanese B Encephalitis Virus and Vaccines: Studies on the biochemical, biophysical and immunogenic properties of the virus and vaccine of Japanese B encephalitis have been made in order to determine whether a vaccine suitable for human use could be obtained by means of differential centrifugation of extracts of infected mouse brains. Although vaccines were obtained possessing about twice the immunogenic potency of the initial material, it was concluded that the method was not practical for the production of a vaccine on a large scale.

The use of different diluents in the titration of virus activity, and the use of different agents in the preparation and storage of the virus suspensions were investigated. It was found that low titers were obtained when Ringer's solution, phosphate buffer at pH 7.0, or saline-phosphate buffer at pH 8.2 were used as diluents, but that high titers were obtained when 10 per cent rabbit serum in saline or in phosphate buffer, 10 per cent skim milk in saline or in phosphate buffer or 1 per cent arginine at pH 8.3 were used. Undiluted skim milk adjusted to pH 8.4 was found to be as satisfactory as undiluted rabbit serum for the preparation of infected brain suspensions for storage at -70° C. and subsequently diluted with 10 per cent skim milk in saline. The demonstration that skim milk can be substituted for rabbit serum in the storage, titration, and neutralization tests of the virus of Japanese B encephalitis is of practical importance, for skim milk is more convenient to prepare and more readily available in many localities. (OEMcmr-158, Duffy and Stanley, Rockefeller Inst. Med. Res., Ms. for publication - CMR Bulletin #54)

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(Not Restricted)

Propylene Dichloride: Propylene dichloride is one of the new solvents that is being used in various Navy Yards as a substitute for carbon tetrachloride. Dr. Leon Heppel of the Division of Industrial Hygiene of the National Institute of Health has studied the potential toxic hazard of this agent and makes the following report:

A. Exposure to a concentration of 2200 parts per million for seven hours per day is fatal to laboratory animals after only a few days.

B. Exposure to a concentration of 1000 parts per million (1-1000) for seven hours per day proved fatal after twenty days.

C. Animals on low protein-low choline diets showed a greatly increased susceptibility to dichloropropane as compared to control animals.

These findings indicate that the same strict precautions in handling propylene dichloride are to be observed as those prescribed for the handling of carbon tetrachloride which has a similar toxicity.

(Not Restricted)

New DDT Insecticide Sprayer: The new continuous-spray type insecticide sprayer, so popular in the Pacific, has recently been made available to all continental Naval activities. This sprayer which is best described as a "Super-Flit gun", is of three-quart capacity and has been designed especially for the dissemination of DDT solutions or emulsions for larvicidal or residual effect. Controlled atomization is effected through an air-regulator. The discharge has a wide range of adjustments, from a forceful penetrating spray to a fine floating fog, with in-between variations made possible by a simple manipulation of the regulator.

The sprayer is very sturdily built, compact and convenient to handle. A funnel-shaped pump end serves as a support when the sprayer is set down for pumping up to high pressures, or when not in use.

This item is in adequate supply and is now stocked at Navy Yard, New York, at the Naval Supply Depot, Oakland, California, and at all major supply activities. Requisitions should be made through supply officers and should specify the following:

(Not Restricted)

FSSC NumberItemUnit

41-S-4120

Sprayer, Liquid, Insect, Continuous Spray, 3 quart capacity

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(Not Restricted)

Shipboard Training Plans: The Training Branch of BuMed has prepared four training plans to assist Medical Officers in meeting their teaching responsibilities aboard ship. The plans include a Dock-side Training Plan for All Hands, a Dock-side Training Plan for Medical Department Personnel, an Under-way Training Plan for All Hands, and an Under-way Training Plan for Medical Department Technicians.

## (Not Restricted)

Printed copies of the plans are available upon request of Medical Officers to their local Training Aids Section or Library or to BuMed. (Pers Div. - BuMed - D. F. Smiley)

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(Not Restricted)

Empty Ammunition Containers for Emergency Flotation: The need for means of floating injured personnel and survivors clear of a sinking ship is obvious. Empty ammunition containers have been suggested for this purpose by several medical officers, perhaps first by Commander M. F. White, MC(S), USNR, who used two powder tanks lashed to a Stokes litter.

Further study of this emergency measure has been carried out by the Naval Medical Research Institute at Bethesda, Maryland, resulting in the following suggestions for emergency flotation:

1. Stokes litter and patient may be floated by lashing two 5/51 cartridge tanks Mk10 to each side of the litter, with one 5/51 powder tank Mk7 at the head.
2. Stokes litter and patient may be floated by lashing one 2<sup>1</sup>/25 metal rocket box Mk2-0 to each side of the litter and one 5/51 powder tank Mk7 at the head and the foot.
3. Folding canvas cot and patient may be floated with one 2<sup>1</sup>/25 metal rocket box Mk2-0 lashed to each side and to the head and the foot.
4. Two 5/51 powder tanks Mk7 may be used as emergency life preservers by lashing them high on the chest and back of the patient, the lashings passing under the patient's arms.

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(Not Restricted)

Fellowships in Physical Medicine: The Harvard Medical School announces the Baruch Fellowships in Physical Medicine to provide training for academic and clinical careers in the field of Physical Medicine. Applicants must have an M.D. degree from an approved medical school and a minimum of one year of internship in an approved hospital. Fellowships are granted annually but are subject to renewal for a total of three years. The annual stipend is \$2500.00 for single and \$3000.00 for married Fellows. Further information and applications may be obtained from the Dean, Harvard Medical School, 25 Shattuck Street, Boston 15, Massachusetts.

(Not Restricted)

Public Health Foreign Reports:

<u>Disease</u>	<u>Place</u>	<u>Date</u>	<u>Number of Cases</u>
Cholera	Ceylon-Trincomalee District - China-Chekiang, Honan, Hunan, Hupeh, Kansu, Kwangsi, Kwangtung, Kweichow, Shensi, Sikong, Szechwan and Yunnan	Oct. 6-13, '45 Aug. 28, '45	13 (11 fatal) Present
Plague	British E. A. - Kenya Ecuador Great Britain, Malta Italy-Sicily, Palermo Italy-Taranto Morocco (French) Chaouia Region Morocco (French)	Sept. 1-8, '45 Aug. '45 Aug. 25-Sept. 15, '45 Sept. 19, '45 Sept. 8-15, '45 Aug. 21-31, '45 Sept. 1-10, '45	11 (4 fatal) 13 (5 fatal) 21 (1 fatal) 4 (3 fatal) 12 (4 fatal) 15 6
Smallpox	Belgian Congo Brazil British E. Africa, Tanganyika British E. Africa, Kenya	Aug. 18-Sept. 22, '45 July '45 Aug. '45 Sept. '45 Aug. 4-11, '45 Sept. 1-8, '45 Sept. 8-15, '45	201 139 142 41 160 (26 fatal) 204 (48 fatal) 91 (9 fatal)

(Not Restricted)

Public Health Foreign Reports (Cont.):

<u>Disease</u>	<u>Place</u>	<u>Date</u>	<u>Number of Cases</u>
Smallpox (Cont.)	Bolivia	Aug. '45	235 (32 fatal)
	Colombia, Antioquia Dept.	July '45	139 (1 fatal)
	Morocco (French)	Aug. 21-31, '45	94
	Rhodesia, Northern	Sept. 21-30, '45	92
		July 28-Aug. 4, '45	638 (2 fatal)
		Sept. 8-15, '45	167
Typhus Fever	Algeria	Aug. 11-20, '45	29
	Belgian Congo	Sept. 22-29, '45	21
	Colombia, Antioquia Dept.	July '45	107 (6 fatal)
	Ecuador	Aug. '45	95 (3 fatal)
		Sept. '45	57 (9 fatal)
	Egypt	Aug. 4-Sept. 1, '45	108
	Greece-Athens and Piraeus	Aug. '45	69 (1 fatal)
	Guatemala	July '45	363 (35 fatal)
	Morocco (French)	Aug. 21-Sept. 30, '45	301
Yellow Fever	Belgian Congo-Irebu Bolivia, La Paz Dept.	Sept. 11, '45	1 (suspected)
	Gold Coast-Tamale	June '45	1 fatal
		Sept. 8-15, '45	1 suspected, fatal
	Peru-Junin Dept.	Oct. 11, '45	3 (unconfirmed)
	Venezuela-Zulia State	Oct. 11, '45	1 fatal

(Pub. Health Reps., Oct. 5, 12 &amp; 19; Nov. 2 &amp; 9, '45)

\* \* \* \* \*

~~RESTRICTED~~

To: All Ships and Stations.

(Not Restricted)

Op13-1D-psp

Serial 580413

Subj: U. S. Naval Special Hospitals, Disestablishment  
of Certain.

15 October 1945

- Ref: (a) SecNav ltr. Op13C-jc, serial 104813, of 27 May 1943; N. D. Bul. Cum. Ed. 1943, 43-1067, p. 14.  
 (b) SecNav ltr. Op13-1D-hc, serial 186213, of 27 June 1944; AS&SL Jan. - June 1944, 44-715, p. 22.

1. The following activity is hereby disestablished effective on or about 1 November 1945:

U. S. Naval Special Hospital,  
Harriman, New York.

2. The following activity, established by reference (a), is hereby disestablished effective on or about 15 December 1945:

U. S. Naval Special Hospital,  
Yosemite National Park, California.

3. The following activity, established by reference (b), is hereby disestablished:

U. S. Naval Special Hospital,  
Beaumont, California.

4. Bureaus and offices concerned take necessary action.

--SecNav. James Forrestal.

\* \* \* \* \*

To: All Ships and Stations.

(Not Restricted)

Op24A-mml/pd

Serial 7P24

Subj: U. S. Naval Special Hospital, Asbury Park, N. J. -  
Disestablishment of.

29 October 1945

- Ref: (a) SecNav ltr. Op13-1D-psp, serial 148413, of 31 Mar. 1945; N. D. Bul. of 15 Apr. 1945, 45-332.  
 (b) SecNav ltr. Op13-1D-psp, serial 313313, of 29 June 1945; N. D. Bul. of 30 June 1945, 45-687.

1. The following activity, redesignated by reference (b), formerly U. S. Naval Convalescent Hospital, Asbury Park, N. J., established by reference (a), is hereby disestablished effective on or about 1 April 1946:

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Bumed News Letter, Vol. 6, No. 12

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U. S. Naval Special Hospital,  
Asbury Park, New Jersey.

2. Bureaus and offices concerned take necessary action.

--SecNav. James Forrestal.

\* \* \* \* \*

To: All Ships and Stations.

Op21D-psp  
Serial 110P21

Subj: U. S. Naval Military Government Hospital No. 201,  
Majuro, Marshall Islands - Establishment of.

30 October 1945

1. The G8 #38 functional component of the military government of Majuro is hereby established under a medical officer in command and designated:

U.S. Naval Military Government Hospital No. 201, Majuro, Marshall Islands.

2. Bureaus and offices concerned take necessary action.

--SecNav. James Forrestal.

\* \* \* \* \*

(Not Restricted)

To: All Ships and Stations.

BuMed-Z-IJH  
A4-1/FS

Subj: Care and Readiness of Medical Departments of  
Vessels in Inactive Status.

4 October 1945

Ref: (a) Ltr. BuMed-T-RLJ, A2-2/EN10(113-38), of 21 July 1944; AS&SL  
July-Dec. 1944, 44-921, p. 198.

Enc: (A) Instructions for Care and Readiness of Medical Departments of  
Vessels in Inactive Status.

1. Reference (a) is hereby canceled and superseded.

2. Enclosure (A) is promulgated for information and compliance in placing vessels in the inactive status and the care and readiness of vessels in that status.

--BuMed. Ross T McIntire.

Enclosure (A)

INSTRUCTIONS FOR CARE AND READINESS OF MEDICAL DEPART-  
MENTS OF VESSELS IN INACTIVE STATUS

(Not Restricted)

## Chapter 1 - Readiness

1-1. The term "inactive status" as it applied to vessels and as used herein includes all vessels in the following conditions (see art. 637, U. S. Navy Regulations, 1920):

- a. In commission, in reserve
- b. In service, in reserve
- c. Out of commission, in reserve
- d. Out of service, in reserve

1-2. When a vessel is designated by the Chief of Naval Operations to be disposed of, article 1510, U. S. Navy Regulations, 1920, applies. Article 640, U. S. Navy Regulations, 1920, does not apply.

1-3. Readiness. Article 640, U. S. Navy Regulations, 1920, requires the following material condition of readiness for all vessels in inactive status:

- a. Habitability for berthing and messing.
- b. Hull, ordnance, machinery, and other equipment in good operable condition fully assembled.
- c. Full allowance of equipage and supplies stowed on board.

1-4. The medical officer and hospital corpsmen of a vessel being placed in inactive status shall not be detached until all preservation measures have been accomplished scrupulously and thoroughly, an inventory has been taken, all records have been completed, and the medical department spaces cleaned and put in shipshape condition throughout. The Bureau of Ships will bear the costs of preservatives and preservation equipment which are common to other bureaus.

## Chapter 2 - Preservation

2-1. Materials retained on board vessel in inactive status shall be protected against deterioration from corrosion, verdigris, tarnish, mildew, mold, and rot. Preservation measures are to be applied by the crew before the vessel is placed in inactive status.

2-2. The current commissioning allowances list for type vessel, together with a list of items subject to deterioration, freezing, or of an inflammable nature, will be furnished the vessel by the Bureau of Medicine and Surgery upon receipt of advice that a vessel is to be placed in inactive status. A full allowance for type vessel of spare parts, equipment, and consumable supplies, except for items exempted by these instructions (par. 3-1(b)), shall be retained in the vessel. The current commissioning allowance received will be considered as a minimum allowance of stores to be maintained on board. Quantities in excess of the allowance list may be retained on board or transferred for local distribution

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at the discretion of the commander of the group or berthing area.

2-3. The preservation measures prescribed for vessels in inactive status consist chiefly of the following:

- a. Dehumidification of the entire vessel.
- b. Preservation of corrodible surfaces not otherwise protected by paint, and except for above decks, by plating or galvanizing and the like, by use of Thin-Film Rust-Preventive Compound (Polar type).
- c. Preservation by special means such as applied to underwater hull, weather decks, rigging, ship's boats, etc.

### Chapter 3 - Placing a Vessel in Inactive Status

3-1. The medical officer of a vessel to be placed in inactive status shall:

- a. Conduct an inventory of equipment and supplies to check against the current commissioning allowance for type vessel.
- b. Transfer, at book value (on SandA Form 127), all items which are subject to deterioration, freezing, or inflammable, as listed in paragraph 2-2 above, and which are fit for reissue to the nearest medical supply depot or store-house. All material of this nature which is not fit for reissue shall be surveyed and destroyed.
- c. Prepare, ready for use when orders are received placing the vessel in active status, requisitions for all perishable or inflammable and other supplies to bring stock up to commissiong allowance. A copy of each requisition shall be forwarded to the Bureau of Medicine and Surgery for requirements purposes.
- d. Make requisition on nearest naval medical supply source for all articles required to bring stock up to minimum allowance and for all items requiring replacement, are missing, or found unfit for use.
- e. Arrange with the reserve group or berthing area commander for the safe storage of narcotics, alcohol, and alcoholic liquors in accordance with current instructions.
- f. Except for the items mentioned in subparagraph (b), store properly all medical supplies and equipment on board, using regular storage spaces. Remove all supplies and equipment from first-aid boxes, battle lockers, battle stations, kits, etc. Prepare list of material removed from each and indicate the former location or the ship compartment number or other means of identification.
- g. Remove all dry-cell batteries installed in medical equipment or outfits, such as flashlights, diagnostic instruments, etc. All articles from which dry-cell batteries have been removed shall be so marked indicating types and numbers of batteries required to make the articles ready for use. Indicate by notes on requisitions (paragraph 3-1(c)) for material subject to deterioration specific equipment for which batteries are being requested.

(Not Restricted)

- h. Transfer the custody of medical department property retained on board to the group or berthing area commander or the custodian designated by him. Forward original (SandA Form 127) and two receipted copies of transfer to the Bureau of Medicine and Surgery.

3-2. Medical officers of vessels, in inactive status, designated to mess and berth the administrative or maintenance personnel complements, shall in addition to the commissioning allowances, retain on board such vessels a minimum of 3 months stock, plus stock required during replenishment interval, of consumable supplies based on the average rate of use for the fixed complement assigned to the commander of the group or berthing area served.

3-3. All metal furniture, installed equipment, instruments, and appliances with corrodible surfaces unprotected by paint, galvanizing, plating, etc., which are retained in ships in the inactive status shall be preserved in a "ready to operate" condition of assembly by treatment with a rust-preventive compound. The various compounds to be used shall be in accordance with "Bureau of Ships --Specification 52-C-18 Compound, Rust-Preventive Thin Film (Polar type)." These compounds will be obtainable from a supply made available to the ship under Bureau of Ships cognizance. Application of the compounds may be accomplished by dipping, flushing, brushing, or spraying, as appropriate. It is not necessary or desirable to disassemble the equipment for application to interior surfaces where this can be done by introduction of the compounds by flushing or spraying through access openings. In the application and use of the compounds, especially when spraying, due care should be exercised to insure adequate ventilation of the working space. The same precautions should be followed as prescribed for the use of kerosene.

3-4. a. Inactive records shall be transferred or disposed of in accordance with current instructions.

b. When a ship is placed in the inactive status the correspondence files and records (except property records, see par. 4-3(d)) are to be properly arranged, packaged in numbered boxes or other suitable numbered containers, inventoried within each box or container, and left in the custody of the commanding officer. One copy of the inventory shall be placed in each box or container used to package the records, one copy shall be attached to the outside of each box or container, and one copy shall be forwarded to the Bureau of Medicine and Surgery for use in determining possible future disposition or retirement of records.

c. Prepare a "key for return of vessel to active status" in triplicate indicating location of records and specific information relative to each subparagraph 3-1 (a) to (h), inclusive. Place one copy of key in a conspicuous location in the sick bay. Provide the commanding officer of the ship with the second copy to be included in his files, and forward the third copy to

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- Bureau of Medicine and Surgery with copy of the records and file inventory.

#### Chapter 4 - Readiness and Care of Vessels While in Inactive Status

4-1. During the period that vessels are in inactive status, readiness for return to active status under the conditions of national emergency must be the first consideration.

4-2. Readiness, security, maintenance, and the routine of carrying on preservation measures, inspections, and inventories for all vessels in inactive status shall be the function of naval personnel assigned.

4-3. In general, the work required in medical-department spaces of vessels in inactive status consists of the following:

- a. Maintain the condition of readiness and security of all medical equipment and supplies.
- b. Comment on preservation measures with recommendation for improvement in methods, preservation, stowage, and security.
- c. Conduct annual inventory of equipment and consumable supplies and replenish as necessary. Make frequent inspections of medical-department spaces and report to commanding officer or officer in charge any deficiencies noted on inspections.
- d. Maintain medical-department file for each vessel in the group consisting of: (1) Journal of Receipts and Expenditures of Medical Department Property; (2) Medical Department Property Ledgers; (3) copies of inventories, surveys, requisitions, invoices, transfer vouchers, and all other correspondence pertaining to individual ships on and after date of entering "inactive status." All these records shall be maintained and financial reports in connection therewith shall be submitted in accordance with the instructions contained in the Manual of the Medical Department and current Bureau directives.

4-4. Medical supplies of less durable nature retained on board these vessels shall be rotated by the group of area medical officer by use of fresh supplies on hand in the minimum stock allowance. Each withdrawal shall be promptly replenished with new stock.

4-5. Full allowances of equipment and consumable medical supplies shall be maintained on board, except as specifically directed by the Chief of the Bureau of Medicine and Surgery after approval of the Chief of Naval Operations.

#### Chapter 5 - Return of Vessels to Active Status

5-1. The medical officer of a vessel to be placed in active status shall:

- a. Procure custody of files, records, and all property of the medical department or under the technical cognizance of the medical department.
- b. Review and forward to Bureau of Medicine and Surgery requisitions prepared in advance for all perishable or inflammable supplies and for other material to bring stock up to full commissioning allowance. Indicate on these requisitions delivery point and the day on which the material ordered must be on board.
- 5-2. a. Procure custody of narcotics, alcohol, and alcoholic liquors.
- 5-3. Prepare medical department in all respects for active service.

To: All Ships and Stations.

(Not Restricted)

Pers-32A-ik

30 October 1945

Subj: Visual Requirements of Candidates for the Naval Academy and for Commission in the Regular Navy.

Enc: (A) Copy of BuPers-BuMed joint ltr. of 22 Oct. 1945, approved by SecNav.

1. Enclosure (A), recently approved by the Secretary of the Navy, is promulgated for information of the service.

--BuPers. W. M. Fechteler.

Pers-32A-ik, P2-5

22 October 1945

JOINT LETTER

From: The Chief of Naval Personnel

The Chief of the Bureau of Medicine and Surgery

To: The Secretary of the Navy

Subj: Visual Requirements of Candidates for the Naval Academy and for Commission in the Regular Navy

1. The Chief of Naval Personnel and the Chief of the Bureau of Medicine and Surgery have during the past several months given considerable study to the subject of visual requirements of naval personnel, including candidates for the Naval Academy and officers of the Regular Navy.

2. In view of the excellent record of accomplishment of officers and men who have a moderate degree of visual refractive error during this war, it appears that visual standards have been too high. Liberalization of standards has already

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been effected with regard to enlisted personnel and with regard to Reserve and temporary officers who transfer to the Regular Navy. The following proposed standards for Naval Academy candidates and for officers of the Regular Navy have been agreed upon by the Chief of Naval Personnel and the Chief of the Bureau of Medicine and Surgery, and are submitted for approval:

- (A) Candidates for the Naval Academy - all candidates for the Naval Academy shall be examined under a cycloplegic.
- (1) Visual requirements shall be 20/20 in each eye without cycloplegic.
  - (2) A refractive error greater than minus fifty one hundredths diopters in any one meridian is in itself a cause for rejection.
- (B) Candidates for commission - line:

A candidate shall have 15/20 vision or better in each eye correctible to 20/20 for a commission in the line of the U. S. Navy.

- (C) Candidates for commission - staff corps:

A candidate shall have 8/20 vision or better in each eye, correctible to 20/20 for commission in the staff corps of the Regular Navy.

- (D) Commissioned officers for promotion, Regular Navy:

General-service officers shall be found visually qualified unless faulty vision is of such degree as to interfere with proper performance of duty at sea or in the field.

- (E) Engineering duty only, etc.:

Visual-acuity requirements for officers to be assigned to engineering duty only and other specialized duty that may be now or hereafter authorized by law shall be the same as for the staff corps.

- (F) Aviation:

Visual specifications for aviation will be separately prescribed.

3. Approval is recommended.

--Ross T McIntire

Vice Admiral (MC) USN

Chief of the Bureau of Medicine and Surgery

--Louis Denfeld

Vice Admiral, USN

Chief of Naval Personnel

Approved: 22 October 1945

--Forrestal,

Secretary of the Navy

To: All Ships and Stations. (Not Restricted)

Subj: Physical Examination Prior to Release BuMed-Y-rw, P2-5/P19-1  
From Active Duty or Discharge From MarCorps 1865-20  
the Naval Service, Modification of Separation BuPers P2-5  
Procedures Involving Venereal-Disease 31 October 1945  
Problems.

Ref: (a) BuMed-MarCorps-BuPers joint ltr. BuMed-RP-IMB, P2-5/P19-1;  
MarCorps 1865-20; BuPers P2-5, of 2 Aug. 1945; N. D. Bul. of 15  
Aug. 1945, 45-998.

1. Paragraph 6 (e) of reference (a) is hereby modified by the addition of the following:

"However, this does not apply in the case of an individual presenting an infectious or communicable disease if the disease constitutes a public health menace."

2. Paragraph 8 of reference (a) is hereby canceled and the following substituted therefor:

8. The general policies expressed in paragraph 6 (as modified) are interpreted in the case of venereal disease to mean that no one with venereal disease in a communicable state shall be released from the naval service until the patient has been rendered noninfectious and not a menace to the public health. These policies shall be effectuated as follows:

(a) A presumptive Kahn serologic test for syphilis shall be made on all persons about to be discharged or released from active duty in the naval service. This test shall be performed as part of the routine physical examination and the results entered in the individual's health record prior to completion of discharge or release.

(b) Personnel who have signs, symptoms, or findings of a venereal disease in an infectious state shall be retained in service (transferred to a naval hospital) for further diagnostic study if necessary and for treatment.

(c) Health records containing any entry indicating the individual concerned has or has had a venereal disease and the health records of personnel whose separation blood test is reported doubtful or positive shall be segregated. A medical officer shall review these health records, determine in which of the following categories each individual concerned falls, and direct appropriate processing as indicated below:

(Not Restricted)

Category A: This category includes personnel with a negative separation blood serology who have a history of venereal infection with clinical observations and adequate follow-up examinations, including spinal fluid in syphilis cases, over a period of not less than 1 year in case of syphilis and 3 months in the case of gonorrhea. These cases may be reasonably assured of a cure.

Procedure: (a) Each individual falling in this category shall be personally interviewed and given both verbal and printed advice and instructions (NavMed-911) appropriate to his status.

Category B: This category includes those personnel, regardless of the separation serology, who have a history of venereal infection within a time period or with a clinical course, or with incompletely treated, who require further follow-up examination or treatment before reasonable assurance of cure can be given (includes syphilis treated with penicillin within 1 year of separation, gonorrhea treated with penicillin within 3 months of separation, and those requiring continuation of arsenic and bismuth treatment of syphilis). These cases have no clinical evidence of infectiousness.

Procedure: (a) Each individual falling in this category shall be personally interviewed and given both verbal and printed advice and instructions (NavMed 912) appropriate to his status. (b) An abstract of the pertinent venereal-disease information contained in the health records of these individuals shall be made on FSA-USPHS Form 9576-B (Separation Epidemiologic Report), including the results of the separation presumptive Kahn test.

Category C: This category includes those personnel who have had no history of venereal infection and who, upon examination, reveal no clinical signs or symptoms of venereal infection, but who have a doubtful or positive separation serologic test for syphilis.

Procedure: (a) Each individual falling within this category shall be personally interviewed and given both verbal and printed advice and instructions (NavMed 913) appropriate to his status. (b) A notation of any pertinent information (recent malaria or vaccination, etc.) contained in the health record that might explain the serological reaction in these cases shall be made on FSA-USPHS Form 9576-B (Separation Epidemiologic Report), including the results of the separation presumptive Kahn test.

(d) FSA-USPHS Form 9576-B (Separation Epidemiologic Report) shall be completed in quadruplicate for each separatee in categories B and C and shall be forwarded daily to the regional U. S. Public Health Service separation office for the area in which the naval activity is located.

(e) Excepted from the provisions of subparagraphs (c) and (d) are all persons

(Not Restricted)

who are to be immediately reenlisted or recalled to active duty and have doubtful or positive presumptive Kahn serology test. Such persons may be reenlisted or recalled to active duty and transferred to a naval hospital for further study.

(f) Initial distribution of printed instructions (NavMed 911, 912, 913) and of FSA-USPHS Form 9576-B (Separation Epidemiologic Report) required by subparagraph (c) will be made directly to separation centers in amounts commensurate with anticipated daily loads. Requisitions for additional supplies shall be made to BuMed.

(g) Consultation and assistance in implementing the above procedures will be available from district venereal disease control officers upon request to the district Medical officer or river command senior medical officer.

--MarCorps. A. A. Vandegrift.

--BuPers. W. M. Fechteler.

--BuMed. Ross T McIntire.

Approved: 30 October 1945

--Artemus L. Gates,  
Acting Secretary of the Navy.

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(Not Restricted)

To: All Ships and Stations.

Pers-3M-ah, P2-5  
26 October 1945

Subj: Annual Physical Examinations.

Ref: (a) BuMed-USMC-BuPers joint ltr. of 12 Oct. 1945; N. D. Bul. of 15 Oct. 1945, 45-1462.

1. Reference (a) is hereby modified to the extent that those physical examinations required during the current calendar year will be postponed until 1 February 1946 or as soon thereafter as is practicable.

2. The postponement is necessary because of the additional work load imposed upon medical-department personnel in the field by the currently accelerated rate of demobilization.

--MarCorps A. A. Vandegrift.

--BuMed. Ross T McIntire.

--BuPers. Louis Denfeld.

Approved: 26 October 1945

--A. L. Gates,  
Acting Secretary of the Navy.